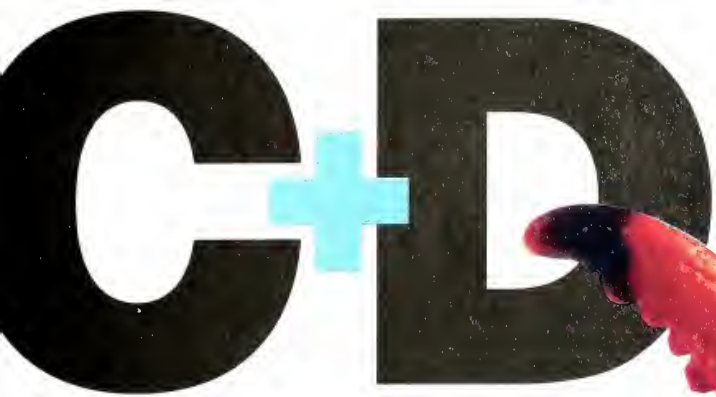




£400m category M clawback

LPC chief officer
Mike Holden looks at
the impact on pharmacy

A proposal

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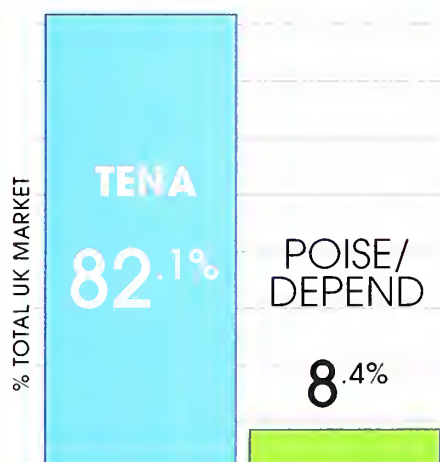
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UK sales of bladder weakness products 2007



(Source: IRI 52 w/e December 1 2007 Total Market Value Sales)

TENA Lady	Pip code	Box contents
MINI MAGIC	320-1183	6 X 34 (204)
ULTRA MINI	272-5133	10 X 28 (280)
ULTRA MINI PLUS	325-4661	6 X 24 (144)
MINI	277-8215	10 X 20 (200)
MINI PLUS	280-6859	10 X 16 (160)
NORMAL	259-4448	6 X 12 (72)
EXTRA	259-4455	6 X 10 (60)
EXTRA PLUS	304-1639	6 X 8 (48)



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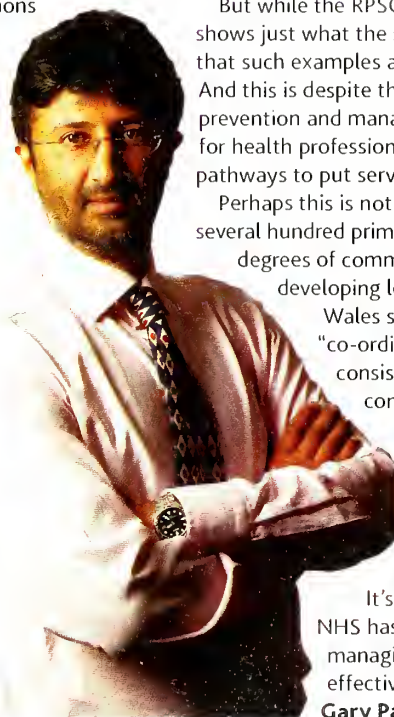
Comment from the Editor

It has been predicted that by 2020 the NHS will grind to a halt. The huge increase in demand for health services created by the current public health maladies will simply overwhelm the organisation's people and infrastructure.

The threat of such a scenario has been the principle driver for the sustained investment and budget controls in the NHS over the past decade. Put simply, primary care has been charged with keeping patients – particularly those with chronic conditions – out of expensive hospitals.

And an excellent example of how pharmacists can, and do, provide a solution to the problem has been released by the RPSGB's Welsh Board this week (p4) to coincide with the publication of Wales' three-year plan for improving the management of chronic conditions.

The RPSGB's document makes some interesting points, not least that the average community pharmacy in Wales serves 327 patients with asthma, 44 with COPD, 185 with angina, 161 who have had a heart attack, 57 with heart failure, 173 with diabetes, and 462 with arthritis. The document further details 25 examples of pharmacy-led services that actively manage some of these chronic conditions. If ever our paymasters needed evidence of what pharmacy can



This smorgasbord of evidence shows just what the sector can deliver

do, then this is a pretty good starting point.

But while the RPSGB's smorgasbord of evidence shows just what the sector can deliver, the reality is that such examples are usually rare and short-lived. And this is despite the increased focus on disease prevention and management through new contracts for health professionals and re-engineered patient pathways to put services in the heart of communities.

Perhaps this is not such a revelation when you have several hundred primary care organisations with varying degrees of commissioning expertise responsible for developing local health services.

Wales says its three year plan to deliver "co-ordinated, comprehensive and consistent" services to manage chronic conditions will require a "proactive, planned and integrated approach".

It would perhaps be wise to ensure this is accompanied by a strong, central hand that ensures a level playing field for those looking to provide such services.

It's not long until 2020 and, while the NHS has started to tackle the problem of managing long-term conditions more effectively, plenty can still be done.

Gary Paraguri, Editor

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Cover photograph by Getty Images

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Heavyweight push for national obesity service

Coventry Teaching PCT has secured funding for a second year of evidence gathering

Zoe Smeaton

Obesity management schemes moved a step closer to becoming a nationally commissioned service this week. Members of the all-party pharmacy group (APPG) met to learn more about how such services could be rolled out nationally.

The group learnt that the Coventry Teaching PCT obesity management project, which has been gathering evidence that community pharmacy weight management services work, has secured funding to run for a second year.

Laurence Tressler, deputy head of medicines management at the PCT, described how the scheme would be rolled out to more pharmacists, using those already on the programme as mentors. He said: "If we have a second tier of pharmacists, then we've got a great system for rolling it out."

The APPG includes pharmacy bodies and representatives, as well as MPs, and the group heard how the Coventry service has enabled patients to lose weight in a slow, sustainable manner, without using drugs.

Several members of the parliamentary health select committee attended the event, and

following it, Howard Stoate, MP, said: "Politicians need to wake up and need to realise that pharmacists are a major part in improving the health of this nation." He added that the event had been a step in the right direction. "Events like this definitely help... they are bound to improve communication," he said.

John Goes, a pharmacist involved in the scheme, agreed the event was a success and that things

could now move on. He said: "I think the pharmacy bodies could see that we do mean business... it's up to them now to try and take it forwards and to lobby."

Ten Coventry pharmacists have helped tackle obesity as part of a DH pilot launched in January 2007.

Do you support a national obesity service?
zsmeaton@cmpmedica.com



Fat chance: politicians must 'wake up' to potential of pharmacy obesity service

Key chronic illness role for Wales

Pharmacists in Wales are set to play a major and expanded role in managing chronic conditions.

The Welsh Assembly Government this week released a service improvement plan for chronic conditions. The report said current services were "unsustainable, with an over-reliance on traditional, and often inappropriate, models of care."

As part of the three-year action plan, key areas of development for pharmacy were identified.

Community Pharmacy Wales and the RPSGB welcomed the report and said it would provide new opportunities for pharmacy. The RPSGB's Welsh pharmacy board has launched a resource paper giving examples of novel practice in Wales to coincide with the launch.

Cath Savage, RPSGB director for Wales, said the challenge for the profession was to work together to meet the targets. She added: "It's really exciting because there are some pharmacy specific objectives against which local health boards will now be assessed."

The pharmacy targets included:

- become fully engaged with e-communications across care settings, and e-prescribing
- substantially reduce medicine related hospital admissions
- improve public and patient education about medicines use
- work with LHBs to ensure effective delivery of enhanced services. **ZS**

£4,000: another postal strike penalty

A Kent pharmacist is £4,000 out of pocket because his September prescriptions were delayed by postal strikes.

John Shaw, of Focus Chemists, Rochester, was alerted to the problem by C+D's article on fellow contractor Val Turner (C+D, February 9, p6). Ms Turner's September NHS payment was down £1,000 after the Prescription Pricing Division processed that month's scripts at October's reduced category M prices. The scripts were delayed in reaching the PPD because of last autumn's Royal Mail walk-outs.

Mr Shaw was contacted by the PPD about the hold up, and again

when the scripts arrived. But it was only when he read about Ms Turner's plight that Mr Shaw realised his low September payment could have been caused by the same error.

He said: "If I hadn't seen the

[C+D] article, I probably would have thought: 'That's a low figure, I must have had a slow month'."

A PPD spokesperson said: "Over the past few weeks, we have been examining how contractors affected by this strike can be fully

reimbursed and we are now in a position to take that work forward.

"We apologise we have not been able to do this earlier but we will now be contacting those individuals who we know were affected to discuss their reimbursements."

But Mr Shaw was concerned he had been given no timescale for his reimbursement. "PSNC need to put pressure on the PPD," he added.

PSNC said it had written to the PPD to stress the need for a quick resolution to the problem. **JR**

PPD inquiry delays

The results of the investigation into how the NHS prices prescriptions have been delayed.

The PPD's inquiry into scripts switching from exempt to paid status was expected to be completed last week (C+D, February 9, p6). But no

conclusions have yet been reached.

The PPD's Michael Wood said it was in three-way talks with PSNC and the Department of Health. "We haven't got to a stage where everybody's agreed we've looked at enough [prescription samples]," he said.

Have you been affected by the postal strike?
haveyoursay@cmpmedica.com

First MP visits pharmacy

Building Bridges campaign off to a flying start with Lib Dem's Sandra Gidley

Fiona Salvage

Sandra Gidley has become the first MP to visit a pharmacy under C+D's Building Bridges campaign.

The Liberal Democrat health spokesperson visited AR Pharmacy in Totton, Hampshire, last week.

Superintendent pharmacist Michael Reynolds briefed the MP about local issues with three-month prescriptions and the electronic prescription service.

Local LPC chief officer Mike Holden took the chance to tell Ms Gidley about services being considered by the strategic health authority in the area.

Ms Gidley urged ministerial colleagues to follow her lead and visit pharmacies. She said: "It's important for MPs to keep in touch and what they probably haven't noticed is that healthcare is changing on the high street."

"I think it's really important for MPs to know what's available for their constituents to make them healthier and happier," she added.

Ms Gidley was shown around the newly refitted and expanded premises, which includes multiple consultation rooms, and large rooms on the first floor that have the potential to host group meetings.

Mr Reynolds said visits such as Ms Gidley's would be a real eye opener for many MPs. "They don't normally visit pharmacies... they

Getting the low-down: Sandra Gidley with Michael Reynolds



can talk to pharmacists a little bit more in depth on the real problems behind the scenes."

The Building Bridges campaign was launched last month and aims to get as many ministers in England, Scotland, Wales and

Northern Ireland to visit their local pharmacy.

Pharmacy video: SANDRA GIDLEY
www.chemistanddruggist.co.uk

AB to align supplier terms

Alliance Boots is seeking to standardise UK payment terms to its suppliers.

The company has written to suppliers to tell them that from April 1 it plans to make payments 75 days from the end of the month of invoice and that this will also be subject to a 2.5 per cent settlement discount.

The company told C+D that it had previously announced in 2006 that it would align its arrangements with suppliers on a group-wide basis. It added that its procurement strategies were in line with other groups of similar size and scale. **GP**



BUILDING BRIDGES

What's happening where

NORTHERN IRELAND
MLA Kieran McCarthy said he would be "delighted" to support Building Bridges. Are you a pharmacy in Strangford who would like to build a bridge?

SCOTLAND
MSP Jim Mather contacted over a visit to Tobermory pharmacy on the Isle of Mull.

LONDON
Stephen Hammond MP to visit Mount Elgon Pharmacy in Wimbledon.

Wales: Five Rowlands pharmacists sign up to Building Bridges.

HAMPSHIRE
Sandra Gidley is first MP to complete visit after a trip to the AR Pharmacy in Totton.

KENT
Herne Bay – Roger Gale MP to visit Delmergate Pharmacy.
St Mary's Cray – John Horam MP to visit Silversands Pharmacy.

Sign up to get involved in the Building Bridges campaign at:
www.chemistanddruggist.co.uk/buildingbridges

News in brief

AZ products go ZD

Seven AstraZeneca products will be added to the zero discount list from March 1. The manufacturer's decision to adjust its pharmacy rebate scheme means that all doses of Arimidex, Casodex and Seroquel tablets now meet the criteria for the list. For full details: www.chemistanddruggist.co.uk

Society v DDA

The Society has become locked in a row with the Dispensing Doctors' Association over the latter's responsible pharmacist consultation response. DDA chief executive David Baker has reiterated that dispensing could be performed safely and efficiently without the intervention of a pharmacist, after RPSGB president Hemant Patel condemned this claim. www.chemistanddruggist.co.uk

MUR double

Two time saving MUR forms have been launched. The NPA is offering a carbonated form to cut the need for transcription. Rx Systems has developed an electronic version of the revised MUR form agreed by PSNC last year.

www.chemistanddruggist.co.uk

DDA slams MAS

Pharmacy minor ailments schemes (MAS) could destabilise primary care, the Dispensing Doctors' Association has said. Its comments follow a review by the National Public Health Service for Wales, which found a lack of evidence on the effectiveness of pharmacy MAS. Full story online at:

www.chemistanddruggist.co.uk

Yellow Card reporting

Pharmacists should this week receive information packs from the MHRA to encourage them to promote the Yellow Card reporting scheme to patients. The packs form part of a campaign to encourage the reporting of possible medicine side effects.

Men's health training

A training programme to help health professionals target men has been launched by the Men's Health Forum. It includes courses aimed at health professionals, and a course on health at work.

www.menshealthforum.org.uk

Dispensary
TALK

Do you trust the PPD's automated pricing system to get your payments right?



"It would definitely be a no, there are major issues. We have no way to check if the system is reading the prescriptions correctly."

Beran Patel, Brigstock Pharmacy, Croydon



"It's not that I don't trust them, they don't gain anything by cheating us, but the process is lacking an openness and accountability."

Raj Rohilla, Richmond Pharmacy, Surrey

WEB VERDICT:

Yes: ☐ 9%

No: ☒ 91%

Armchair view: We can't go on together with suspicious minds, as Elvis once sang, it seems the King was talking about the relationship between pharmacists and their paymasters. Time things got shook up or pharmacists are heading for Heartbreak Hotel.

This week: Would you join a pharmacy trade union that covered both employees and contractors? Vote at:
www.chemistanddruggist.co.uk

Screen alerts to tackle smartcard expiry fears

IT warnings to prevent time-consuming renewal process

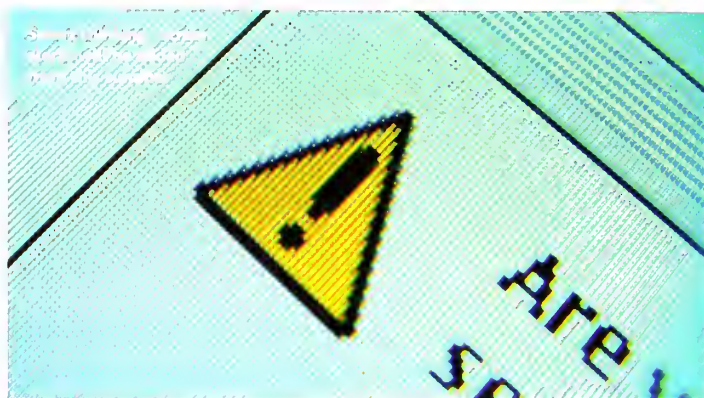
Zoe Smeaton

Smartcard users are to be warned via a screen alert that their card certificates are due to expire, Connecting for Health has told C+D. The new facility will be available from the summer, the agency said.

This should ease industry fears that problems will occur when pharmacists have to renew the certificates, which last for two years.

However, despite PSNC guidance on the subject, C+D found this week that some pharmacists are still unclear on how the renewal process will work. And LPC leaders were worried that the process could prove "challenging".

Pharmacists should contact PCT Registration Authorities (RAs) about renewing the certificates. But if they do not renew before the expiry date, they will not be able to



use EPS and will need a face-to-face meeting with the RA.

Vanessa Taylor, professional executive officer of East Sussex LPC, said getting pharmacists to phone to renew smartcards could cause problems in a busy dispensary. Delays in processing calls could mean cards expired before pharmacists had the chance to renew.

Andy Charlesworth, commercial IT manager at Numark, warned that if they left it too late, "it goes from being a simple phone call to rushing in a taxi to get it renewed, and that gobbles up their time".

Did you know you had to renew your Smartcard?
zsmeaton@cmpmedica.com

Iron bar attacker back in RPSGB dock

A pharmacist jailed for attacking a Society official with an iron bar has launched a stinging verbal assault on the RPSGB during a disciplinary hearing.

The tirade came as Samuel Edwin Ashby, 62, was struck off for a second time by the Society's Statutory Committee this week.

Arriving late for the hearing, the Australian pharmacist said: "Shut your f***** guts up. You make me sick – you f***** idiots. I've never had to deal with such ignorant fools in my life."

Mr Ashby was convicted of assault by Inner London Crown court last summer for an attack that left an RPSGB official with a 10cm head wound. Asked if he regretted his action, Mr Ashby said: "After the abuse I had to put up with? You expect pharmacists to put up with that abuse? No wonder pharmacists do nothing."

The Society said it had struck off Mr Ashby for a second time after

he launched a High Court appeal against his initial dismissal from the register in October 2006.

A second striking off was "double protection" against Mr Ashby working in a pharmacy again, the RPSGB said.

However, Mr Ashby could still return to the register temporarily if he appealed against this week's decision, the Society added.

Mr Ashby used the hearing to turn on pharmacy standards in the UK. "I have never had to work in such conditions in my life." Pharmacy staff were "pillaging, raping and abusing" standards, he said.

Mr Ashby had brought the weapon he used to the hearing in anticipation of the attack in 2006, the panel heard. He had also later told a psychiatrist he wished he'd hit him harder, the RPSGB was told.

Mr Ashby has three months to appeal. **UKL**

Increase in crystal meth

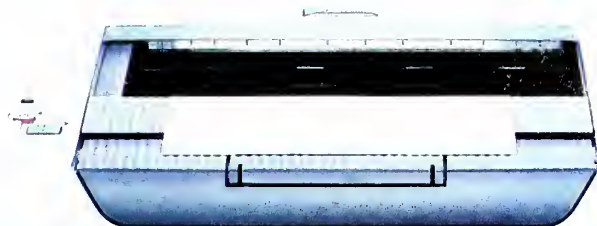
The Association of Chief Police Officers (ACPO) has reported an increase in the use and manufacture of crystal meth.

ACPO would not say if there was evidence of a link to pharmacy sales of pseudoephedrine- and ephedrine-containing medicines, which can be used to manufacture the class A drug in home laboratories.

The pharmacy sector blocked a bid to make all affected medicines prescription-only last September. However, industry representatives said the reported rise should remind pharmacists about tightening sales controls. NPA spokesperson Neal Patel said: "This isn't going to go away. We need to make sure we're ever-vigilant."

ACPO was unable to say whether it would continue to support a blanket P to POM reclassification of pseudoephedrine and ephedrine.

But a spokesperson said: "ACPO is aware of the contributory factor of pseudoephedrine... to the production of crystal meth, and that is a cause for concern." **JR**



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News in brief

Viagra pilot looks up

A Boots pilot scheme for erectile dysfunction problems has helped hundreds of men find out they have undiagnosed health problems, the retailer has claimed. Four out of five men using the service over the last year were referred to GPs with other health conditions, Boots revealed.

Heart success

A target to reduce the number of under 75s dying from cardiovascular disease by 40 per cent has been met five years early, a government report suggests. The CHD National Service Framework Progress Report said faster delivery of thrombolysis and doubling of statin prescriptions have all contributed.

Service development

The NPA has launched an Innovation Partnerships Programme to support local service developments. Pharmacists taking part get a package of bespoke NPA support but must commit to a robust evaluation of their project.

HAG national meeting

The Harmonisation of Accreditation national meeting will be held at Chancellors Hotel and Conference Centre, Manchester, on February 26. It is backed by the RPSGB's English pharmacy board and chaired by one of its members, Gail Thomas.

NI health structure

NI pharmacists are being asked to contribute to a 12-week public consultation on streamlining health and social care. The proposals include a new regional Health and Social Care Board focusing on financial management, performance management and commissioning, a regional Public Health Agency to tackle health promotion and inequalities, and a smaller, more sharply focused Department.

www.dhsspsni.gov.uk

Allergy screening

Free screening will be available in May's National Allergy Week in a project supported by the NPA and DH.

www.allergyuk.org

Twice daily delivery is secure, says AAH chief

» Squeeze on margins will not affect services, boss pledges

Gary Paraguri

Wholesalers' traditional twice-daily delivery service remains secure despite the squeeze on margins caused by new distribution models, AAH has claimed.

While some areas would be subject to cost savings, the delivery and professional services that AAH provides pharmacists will not be affected, the wholesaler's group managing director has said.

Scrapping twice-daily deliveries would force wholesalers to "condense national demand into two hours", managing director Mark James said. This could prove a costly move for suppliers, he stated.

"Our vans don't go out empty, so while they are going out twice, they are going out full... and, if you buy a van twice the size, the fuel efficiency isn't there," he told C+D.

Mr James claimed AAH had not been significantly affected by the loss of the traditional 12.5 per cent margin as pharma companies imposed alternative supply models. Most of that margin was passed to customers, so the "amount



Mark James. Not cost-effective to offer once-a-day service

retained in the supply chain was very small... and the impact [of losing it] isn't that big on what we can and can't do", he said.

The company will instead look to enhance its professional services support, he argued, as part of the drug firms' plans to get closer to their pharmacy customers. Mr James said AAH was "working" on enhanced service models.

He said: "It's not necessarily looking at a particular product but a particular category. It's services that we want to deliver, that we believe pharmacy would find beneficial."

Mr James was speaking exclusively to C+D in his first interview following his appointment last month as AAH managing director.

To hear more from Mr James, including his views on Steve Dunn's departure, and whether wholesalers will provide a dispensing service, see a video of his interview at www.chemistanddruggist.co.uk

Video interview:
MARK JAMES
www.chemistanddruggist.co.uk

Struck off for breaking privacy rules and self-supplying drugs

A Newcastle pharmacist who breached confidentiality rules by asking a "young lad" to deliver the methadone drugs register to his work in a carrier bag has been struck off.

The Royal Pharmaceutical Society panel heard that Christopher Dotchin, 29, had taken home the register to catch up on entries but the next day failed to turn up to work at Alliance Pharmacy, Bedlington.

The incident was one of a series

of complaints against Mr Dotchin, including supplying himself with penicillin and antidepressants, and storing Ritalin outside the controlled drugs cabinet.

The panel heard Mr Dotchin's problems began when his long-term partner was admitted to hospital with a life-threatening condition.

Panel chairman Judge Mota Singh said: "We have come to the view there are some aggravating features –

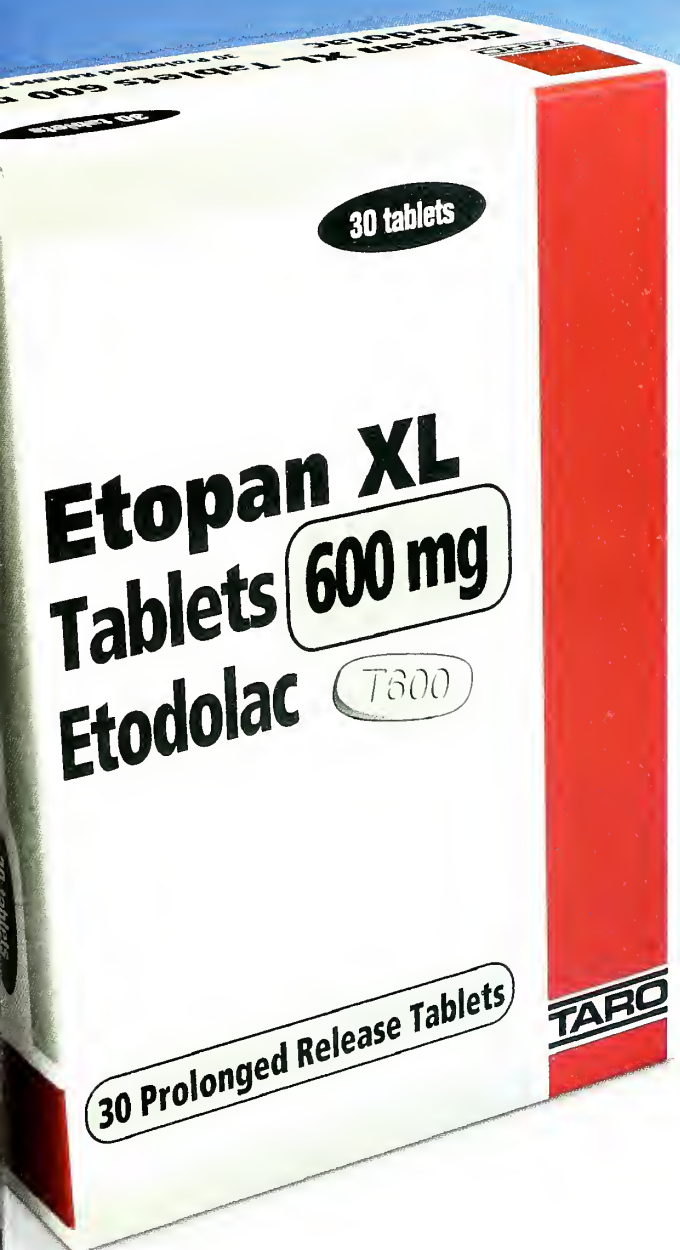
the previous matter, disregard of previous warnings, abuse of trust and breach of confidentiality."

The complaints against Mr Dotchin came while he was working for Moss Pharmacy and Lloydspharmacy at sites in Bedlington, Peterlee in Northumberland and Concord, Tyne & Wear.

Mr Dotchin, who did not attend the hearing, has three months to appeal the decision. **UKL**

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PRESCRIBING INFORMATION

Presentation: Etopan XL Tablets containing 600mg of etodolac in a film-coated prolonged release formulation. **Indications:** Acute or long-term use in rheumatoid arthritis and osteoarthritis. **Dosage and Administration:** Adults: One 600mg tablet daily. Elderly: No change in dosage is generally required unless renal or hepatic function is impaired. Children: Use in children is not recommended. **Contraindications:** Patients with: existing, or a history of, peptic ulceration/haemorrhage; hypersensitivity to etodolac or any of the excipients; a history of asthma, rhinitis or urticaria during therapy with aspirin or other NSAIDs; severe heart failure. **Special Warnings and Precautions:** Caution is required in patients with: a history of hypertension and/or heart failure; existing or a history of, bronchial asthma; compromised platelet function; a history of GI disease (ulcers, ulcerative colitis, Crohn's disease) as their condition may be exacerbated; rare hereditary problems of galactose intolerance, the Lap lactase deficiency or glucose-galactose malabsorption. Patients with renal, cardiac or hepatic impairment should be monitored in case of deterioration following the use of any NSAID. Patients on long-term treatment should be regularly reviewed for changes in renal or hepatic function or haematological parameters. If any sign of GI bleeding or serious skin reactions, including skin rash, mucosal lesions or

other signs of hypersensitivity occur, treatment should be stopped immediately. The elderly are at an increased risk of side effects, particularly GI effects that can be fatal. Undesirable effects may be minimised by using the minimum effective dose for the shortest possible duration. Etodolac SR Tablets should not be used during pregnancy and its use in nursing mothers should be avoided. **Interactions:** Corticosteroids (increased risk of GI effects). NSAIDs may enhance the effects of anti-coagulants such as warfarin. Concomitant use of ciclosporin, methotrexate, digoxin or lithium with NSAIDs may cause an increase in serum levels of these compounds and associated toxicities. Care should also be taken in patients treated with anti-hypertensives, mifepristone (NSAIDs should not be used for 8-12 days after mifepristone administration), other analgesics including all other NSAIDs, quinolone antibiotics (increased risk of developing convulsions). **Undesirable Effects:** The most commonly observed adverse events are gastrointestinal in nature: Peptic ulcers, perforation or GI bleeding, sometimes fatal. Nausea, vomiting, diarrhoea, flatulence, constipation, dyspepsia, abdominal pain, melaena, haematemesis, ulcerative stomatitis, exacerbation of colitis and Crohn's disease. Less frequently, gastritis. Long-term treatment may be associated with arterial thrombotic events. Other side effects include:

Anaphylactoid reactions; serious skin disorders including Stevens-Johnson syndrome and toxic epidermal necrolysis; hepatic function abnormalities and jaundice; oedema, hypertension and cardiac failure; renal problems including renal failure; blood dyscrasias. Prescribers should consult the Summary of Product Characteristics in relation to other side effects. **Legal Category:** POM. **Product Licence Numbers:** 15842/0039. **Date of Preparation of API:** July 2007. **Marketing Authorisation Holder:** Taro Pharmaceuticals (UK) Ltd, Lakeside House, 1 Furze Ground Way, Stockley Park East, Uxbridge, UB11 1BD. **Sole Distributors:** Winthrop Pharmaceuticals UK Ltd, One Onslow Street, Guildford, Surrey, GU1 4YS. **For medical information phone:** +44 8707 369544. **For all other information available freephone:** Winthrop 0800 854431.

Information about adverse event reporting can be found on www.yellowcard.gov.uk. Adverse events should also be reported to the Taro UK Office Tel +44 8707 369544/ email: regulatory@taropharma.co.uk

For further information please freephone 0800 854431 or contact Winthrop Pharmaceuticals, 1 Onslow Street, Guildford, Surrey, GU1 4YS. Fax number 01483 554809. Date of preparation: August 2007 STW 336

Can I have more sir?



A conference organised by the Improvement Foundation has put the spotlight on practice-based commissioning. So just what does the future hold? **Zoe Smeaton** reports

An operation dominated by general practice, where local GPs are more influential than pharmacists and can cherry-pick the best services for themselves. This is how many

pharmacists see practice-based commissioning.

But those attending the Improvement Foundation PBC and Pharmacy Learning Event heard that times look to be changing. With the right action plan, pharmacy could soon boost its position, delegates heard at the event held at the Effingham Park Hotel, near Gatwick.

Last year the DH published a document on World Class Commissioning. This was a vision of how PCTs should run commissioning programmes.

Tim Jones, an NHS commissioning consultant, says the strategies are "long overdue" and could lead to improvements for pharmacists. Mr Jones says that while the standards may be idealistic, it was important to point out to PCTs where they are going wrong. He comments: "PCTs have a lot to learn... let's not underestimate that challenge, but we should be helping them with it."

Stephen Fishwick, head of NHS service development at the NPA, agrees. If PCTs meet the World Class Commissioning standards, more productive relationships could be developed between pharmacists and PCTs. However, improvements could take time, he warns.

One possible improvement is that World Class Commissioning asks PCTs to stimulate the service provider market. This means they should be encouraging contributions from all potential providers, including pharmacy. Mr Jones says: "That's a good point for dialogue and this is something where I think the LPC could get involved."

Furthermore, PCTs should be very clear about which services will or will not be competed for by providers. Such tactics could "solve the problem of GPs being commissioners and providers," Mr Jones predicts.

So PCTs should be improving their methods, but what else can pharmacists do to help themselves?

The first step is to knock on the door of your local GP. Mr Fishwick says: "Talk to your GP first and foremost, ask them what his or her problems are and talk to them about solutions, there's no substitute for doing that."

Both talking and listening are key to success at this stage. Michelle Webster, national PBC lead at the Improvement Foundation, reveals.

Openly airing views and fears to other stakeholders means problems are be acknowledged and solutions found, she says.

Many pharmacists have been wary of approaching GPs, according to Ms Webster. "I think there has been some fear that we're just going to get the door slammed in our face, but we need to step up to the mark."

So, rather than trying to compete with GPs, focus on the end goal, improving patient care, and try to engage usefully with them. Are there things you could be doing to help them? Gianpiero Celino, director of Webstar Health, a pharmacy consultancy firm, advises: "I don't want

people to worry too much at this stage about whether they are working for GPs or with GPs, I think it doesn't make much difference as long as you're working."

Mr Celino believes that being a PBC service provider is not the key to success. Services such as MURs and repeat dispensing could be used to help other providers to demonstrate to practice-based commissioners that pharmacy is making a contribution.

Mr Fishwick advises that such services and strengths should be the starting point. He says: "Pharmacy's unique selling position is its combination of medicines expertise and accessibility, so look at those services first, don't

look enviously across to general practice and say because they can do that I should do it, start where you can make a case for being the best."

And if you're still feeling nervous about proposing a service to the PCT, remember you have the upper hand, says Mr Celino. "You sometimes forget that you don't have to get comfortable with the idea of buying or selling a service, it's what you do every day... you have to compete for every person that comes through the door, and that puts you at an advantage."

Whatever strategy you decide to take though, it's clear that it really is over to you now. No policy document can change the relationship pharmacists have with commissioners, concludes Mr Celino. "Pharmacists hold a great deal of the future with regards to PBC in their own hands and have a great deal of influence over how successful we are in it."

For more information visit www.improvementfoundation.org

“No policy document can change the relationship pharmacists have with commissioners”

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¹ Based on the Minnesota Nicotine Withdrawal Scale (MNWS), Brief Questionnaire of Smoking Urges (BSU-brief) and modified Cigarette Evaluation Questionnaire (mCEQ)

CHAMPIX® Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION – UK. (See Champix Summary of Product Characteristics for full Prescribing Information).

Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8 – End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** Mild to moderate renal impairment: No dosage adjustment is necessary. Patients with moderate renal impairment who experience intolerable adverse events: Dosing may be reduced to 1 mg once daily. Severe renal impairment: 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. Patients with end stage renal disease: Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Effect of smoking cessation; Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs

the risk. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product affects their ability to perform these activities. **Side-Effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side-effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side-effects were increased appetite, somnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for less commonly reported side-effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category:** POM **Basic NHS cost:** Pack of 25 11 x 0.5 mg and 14 x 1 mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1 mg tablets Card (EU/1/06/360/004) £27.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1 mg tablets HDPE Bottle (EU/1/06/360/002) £54.60, Pack of 56 1 mg tablets Card (EU/1/06/360/005) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 10/2007

Adverse events should be reported to Pfizer Medical Information on 01304 616161. Information about adverse event reporting can also be found at www.yellowcard.gov.uk

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References: 1. Gonzales D *et al.* JAMA 2006; 296:47-55. 2. Jorenby DE *et al.* JAMA 2006; 296:56-63. 3. Tonstad S *et al.* JAMA 2006; 296:64-71. 4. Coe JW *et al.* J Med Chem 2005; 48:3474-3477. 5. Gonzales DH *et al.* Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida Abstract PA9-2. 6. CHAMPIX Summary of Product Characteristics.



Date of preparation: November 2007 CHA354a



Xrayser

Something for the weekend, Sir?

Is Viagra about to become a Pharmacy medicine? It seems unlikely, but not beyond the realms of possibility. OTC Viagra would virtually eliminate black market trade, and it has already been supplied under patient group directions, so why not?

The fact that the MHRA has run a conference on men's health (C+D, February 16, p12) makes me think that something must be in the pipeline. Its recent meeting on women's health coincided with the application for a P licence for tranexamic acid as well as providing a forum to raise the issue of OTC supply of the Pill. The Pill OTC was a shocking thought to many at the time, but the idea has since gained credence, and PGDs are due to begin later this year.

Apart from those amazing blue diamond shaped tablets, I can't think of any other exclusively 'male' drugs that might be suitable for switching. Orlistat and azithromycin are no more targeted at men than any other drug. A quick straw poll of X Pharmacy's all female staff revealed that they would like to be selling drugs to men to make them stop snoring, lose interest in football and help with the washing up. I couldn't find a drug in the BNF for any of those indications.

So forget men's health clinics, Viagra for sale would provide men with exactly the "passport" Dr Banks says they need. In fact, it would have men



flocking to us in droves. Displaying packs for sale in the consultation room could trick them inside. Shut the door quick, and you've got another unwilling MUR patient. Get their name and address, stuff some health promotion leaflets in their pockets as they try to escape and you've achieved more for men's health in those few seconds than the profession has managed in 100 years.

Limiting supplies to one tablet at a time would ensure regular repeat visits from previously unhealthy men. They would get used to visiting their pharmacy after a while and might even become comfortable with the idea. Who knows, they may even ask for a bit of advice in a few years' time.

Let's hope that the MHRA does have a hidden agenda to its sudden interest in men's health because it will take a huge carrot to tempt significant numbers of men into pharmacies. And this could be a carrot the size of which only the government can provide.

We would have to consider how to accommodate this previously absent 50 per cent of the population when, and if, it happens. Extended opening hours and

television screens showing Sky Sports might only be the beginning of a whole new business plan. Forget toiletries and nappies, bring on the power tools, car spares and sports equipment...



Locum at Large

Who would want to be a pharmacy manager?



When I qualified in the year dot it was generally the case that a newly qualified pharmacist would work for an employer, usually private, learn the tricks of the trade for a few years and then, if any good, might be fortunate to find a position as manager of a small pharmacy, seen as the bottom rung on the ladder of success.

Any further progression depended on the personality of the individual, the reference from the previous employer and how he (it was almost always he) compared

to the other candidates when applying for promotion.

Fast forward to 2007-08 and how things have changed. Newly qualified pharmacists, no matter gender, race or religion, are now going into the management of large, busy pharmacies straight from college, often, as one major company put it, in a 'sink or swim, hope for the best' scenario. Lack of experience, indeed any experience, is no longer seen as a barrier for appointment to the most onerously responsible positions as companies desperately seek to find the required number of managers for their pharmacies. I have witnessed the most bizarre appointments and quite a few more where eyebrows (not just mine) have been raised. Plus a couple of absolute disasters.

It is one thing learning on the job when there is a senior manager or proprietor to guide you. Quite another when your mentor is an aggressive area manager or pharmacy superintendent, often

miles away, pressurising you to meet the ever over-optimistic targets set for just about every area of performance for your pharmacy. It almost appears that many first appointments are expected to be absolute geniuses in pharmacy management from the off.

That many swim rather than sink is often a matter of luck rather than judgement but let me pay tribute to the many pharmacists who do make a go of it despite all the hazards and brickbats thrown at them. A pharmacy managership these days is no sinecure but an onerously responsible position, often performed in spite of rather than because of any so-called support from higher up.

It saddens me to find that so many area offices, let alone head offices, are often seen by everyone in many pharmacies as a hindrance to good performance rather than a help. And far too many businesses appear to be distracted from offering the best service to the public but instead spend endless

time feeding information and data to remote, parasitic head and area offices. As one manager complained to me, even the simplest return can take several hours to accumulate all the data.

When I sold my businesses some years ago my staff later told me that there had been a 180 degree turnaround in the culture of the business. The customer was no longer king, it was head office and everything fed up to this controlling monster. A flood of returns and documentation flowed in a never-ending stream to and from numerous jobsworths miles away with little conception of the demands of a busy pharmacy.

Since state and company bureaucracy appears to be getting worse, it is amazing anyone still wants to be a pharmacy manager.

Pharmacy manager or locum: which would you choose and why?
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Life at the coalface

From category M clawbacks to 100-hour contracts, Hampshire & Isle of Wight LPC chief officer **Mike Holden** describes the impact on pharmacy

This is the polite version of what my contractors are saying about category M since they fell off the end of the cash flow seesaw when the full impact of the October changes hit home in January. Some even struggled to pay their major wholesaler bill and many have taken the decision to withhold further investment in staff and premises until their financial position becomes more stable and predictable.

“Not only are we supporting the cash flow of the treasury, but our efforts have saved them millions if not billions”

According to feedback locally, the reduction in average net ingredient cost (NIC) for October over September activity varies from 2 per cent to an alarming 17 per cent dependent on the mix of dispensing, with the norm being around 7 per cent. Add this to the effect of PCT-driven prescribing switches to cheaper brands and branded generics, lost discounts and increased administration with direct to pharmacy schemes, inefficiencies at the NHS Business Services Authority (BSA), increasing utilities costs... need I go on?

Yes, there is the argument that this is a rebalancing of overfunding through category M in the first half of the financial year but no one, least of all the hard working single independent who is focused on the needs of his or her patients, anticipated such a significant swing. We are now paying for the savings that our effective buying has given to the NHS drugs bill. Not only are we supporting the cashflow of the treasury, but our efforts have also saved them millions if not billions since the inception of the new financial framework and category M.

At this point perhaps I should also mention the instability that the current control of entry exemptions create. One of my contractors has just invested a very significant amount of money in his business to create an exemplary healthcare practice fit for the future only to have a 100-hour contract application within the same neighbourhood land on his desk just as he was planning his opening celebration event.

The time has come to break the system and replace it with one that works for pharmacy and not just the NHS. A new system that allows pharmacy contractors to know precisely what they will be paid for any one prescription and any one month's work. More importantly, a system that allows them to accurately budget their financial flow over the next 12 months and beyond. We need a system where a contractor invoices the NHS for work completed with a fair return on all activity undertaken with no possibility of completing any service at a loss or having payment delayed. We need a system with new levels of transparency where there is no nebulous retained profit element in the remuneration calculation and discount clawbacks that do not reflect discounts gained.

Those in Whitehall who make decisions about the future of our contractual framework should consider how they would feel if they did not know how much was coming in their pay packet. Suppose they were expected to wait three months to be paid for some of the work they do with no true accountability for errors in the calculation? What if I could apply under some contractual exemption to take away some of the work undertaken by staff at a PCT or NHS BSA and therefore reduce the viability of a position or whole department?

Andrew Lansley MP should think long and hard before making ill-informed comments and consider joining the 'Building Bridges' campaign to see at first hand the work undertaken by a dedicated pharmacy team, much of it unfunded or underfunded. He and other MPs of all parties need to listen to the issues pharmacy contractors face in a climate where the commissioning of new services has rarely happened due to pressures on financial balance and in an environment still dominated by a medical model. Certainly we have a number of visits lined up locally to do just that.

While I actively support and pursue the commissioning of pharmacy based services, it will take a paradigm shift to make up for the funding lost from dispensing within the current framework. For pharmacy to invest sufficiently in premises and skill-mix we need confidence in a robust contractual framework, financial stability and control of entry regulations that allow PCTs to effectively plan the commissioning of services to meet identified needs. Let us hope that the pharmacy white paper delivers on this. So back to the M-factor. I wonder what Simon, Sharon and Louis would make of the line up? It would be interesting to see who or what made it through to the next round.



Mark Griffiths on category M: see p16

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1. IMS Volume data (MAT June 2007) and Care ex factory volume (MAT June 2007)



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Passing the buck

I am increasingly frustrated at the unilateral impositions on community pharmacists. The Prescription Pricing Authority has requested that we significantly alter the way prescriptions are filed and submitted, thereby transferring their work to us – but at our expense.

This will create considerable extra work, possibly up to two hours extra per week, at a time when pharmacists and their staff are doing much more for less already. We are not sure if we are a 'test site' or many others are being asked to do this but we are not happy.

Letters

The PPA can arrange the prescriptions any way they like – once they receive them. We only have to look at other professions to see the strong response they give to extra work commitment requirements from the government. (I have received no pleading letter from Alan Johnson).

Should we be paid for this extra work? Has the PSNC capitulated over this? Is the motto of the PSNC 'Oh, alright then'? Fight our case PSNC or should we mention the DNG [discount not given] shambles?

Roy Gillman, Sheffield Pharmacy, Hertford

Making ends meet



As a practising pharmacist, as well as chairman of buying group Cambrian Alliance, I must warn PSNC and concerned politicians that I, along with many others, are seriously wondering how we are going to make ends meet.

With increasing costs of staff and infrastructure and an extremely significant drop in income from the recent adjustments to category M – up to £3,000 a month – it is reasonable to believe that PSNC does not understand the plight of the independents it represents.

Shadow health secretary Andrew Lansley rightly charged PSNC with complacency over the regard to purchase profits and in the climate of the new contract PSNC seriously needs to re-evaluate the real costs of running a community pharmacy.

One has to wonder what PSNC is

basing its profits on and what allowance it has made for inflation eroding the value of the £500 million retained purchase profit cap agreed three years ago.

We must call on PSNC to lobby harder and impress on the government the true running costs of an independent pharmacy.

All any independent wants is a stable financial climate and an understanding of the impact that last minute, lump sum settlements have on cash flow and overall profits.

To look after purchase profit in the climate of the new contract, when we as independents are being urged to focus on service provision, is an additional challenge to managing our books, let alone our time.

Buying groups like Cambrian Alliance undoubtedly give independents the power of collective purchasing but this is not enough. PSNC needs to take a leaf out of the GPs' negotiating book and secure a better deal for all concerned.

**Mark Griffiths
Chairman
Cambrian Alliance**

Write your letter to the editor
of the journal, Pharmacist, at
21, Abchurch Lane, London EC4N 3DF
or email: letters@pharmacist.co.uk
or fax: 020 7464 1111

MUR Expert Guide: COPD

Medicines Use Reviews – a service for patients, and an opportunity for pharmacists

- The number of pharmacies offering a Medicine Use Review service is increasing and was 25% of capacity by April 2007. Patients are generally positive about their MUR experience¹

CD

MUR Expert Guide: COPD



A Medicines Use Review is a structured, concordance-centred review with patients receiving medicines for long term conditions, such as chronic obstructive pulmonary disease (COPD), to establish that their medicines are appropriate and effective.

The review should help patients understand their therapy and identify any problems they are experiencing, along with possible solutions.

Key Points

- Establish the patient's actual use, understanding and experience of taking medication.
- Identify, discuss and resolve poor or ineffective use of drugs by the patient.
- Identify side effects and drug interactions that may affect the patient's compliance.
- Improve the clinical effectiveness of drugs prescribed to patients.

- Medicines Use Reviews earned NHS pharmacy contractors in England £13.5 million from April 2006 to March 2007²

- Over 203,000 MURs were completed from April to June 2007 (compared to 557,000 in the 12 months to April 2007)²

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A pressing problem

Effective treatment and patient compliance means a glaucoma diagnosis doesn't always equal sight loss

Key points

- Glaucoma affects more than 500,000 people in the UK, mainly in the over 40 age bracket, and is one of the main causes of preventable sight loss.
- There are four different types of glaucoma.
- Reducing intraocular pressure to prevent further damage to the optic nerve is the main goal of treatment.
- Eye drops are the lynchpin of therapy, with topical beta-blockers or prostaglandin analogues generally the drug of choice.
- Of all the treatable diseases, glaucoma has one of the biggest problems with poor patient compliance.

Helen Boreham

Despite being common and treatable, glaucoma remains the leading cause of preventable blindness in the UK. The problem of poor patient compliance – as many as half of all glaucoma patients fail to use their eye drops correctly – is compounded by delays in timely diagnosis that make many patients unwitting sufferers until late in the disease process. No wonder then that glaucoma is often referred to as the 'silent thief of sight'.

Glaucoma is the collective name given to a group of eye disorders in which the optic nerve is damaged at the point where it leaves the eye. In ancient Greek, glaucoma meant 'clouded' or 'a blue-green hue' – probably a description of the corneal oedema that occurs in acute disease.

Glaucoma affects around 2 per cent of

The College of Pharmacy Practice

This course (module 1431), in association with multiple choice questions being published in C+D March 1, provides one hour's continuing education



Reflect

What is the difference between primary open angle and primary angle closure glaucoma? What is secondary glaucoma? How do topical beta-blockers work? When should these not be used?

Plan

This article describes the different types of glaucoma and their causes, together with treatments. There are suggestions as to how pharmacists might encourage concordance and help prevent further damage to sight.

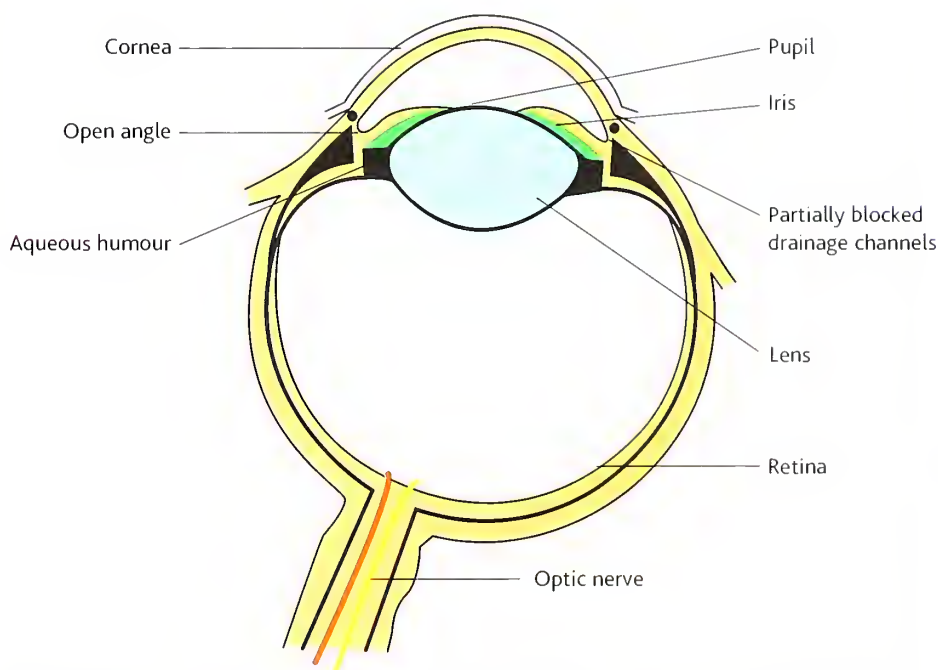


Figure 1: Cross section of an eye from above showing open angle glaucoma

Aqueous humour cannot flow effectively because of partially blocked drainage channels, increasing intraocular pressure and damaging the optic nerve.

people aged over 40 in the UK, with incidence rising to 5 per cent in the over 65s. Overall, it is estimated that more than 500,000 adults in England and Wales suffer from glaucoma. Of these, 13 per cent are registered blind as a result of sight loss wholly or partly attributable to the disease. Glaucoma now accounts for more outpatient attendance at eye departments than any other ocular condition, and incidence seems to be rising. Globally, glaucoma affects 70 million people.

Types

There are four main types of glaucoma:

• Primary open angle glaucoma (POAG)

The most common form, this slow-developing condition occurs as a result of inefficiency in the eye's fluid draining channels (the trabecular meshwork), leading to a build up of intraocular pressure (IOP) as illustrated in figure 1. Because the drainage angle remains 'open', IOP rises very slowly and there is no

Table 1. Types of glaucoma eye drops

Type	Examples	Mechanism of action	Dosing	Possible side effects
Beta-blockers	Betaxolol, carteolol, levobunolol, metipranolol, timolol	Reduce the rate of production of aqueous humour	Used once in the morning or twice a day	Slow pulse rate, dizziness, tiredness, reduction in exercise capacity, depression, loss of libido, impotence
Alpha agonists	Brimonidine, apraclonidine	Decrease fluid production in the eye and may also improve flow of fluid out of the eye	Applied two or three times daily	Dry mouth, general feeling of unwellness
Prostaglandins/prostamide analogue	Latanoprost, travoprost	Improve the flow of fluid out of the eye by the non-conventional (uveo-scleral) outflow pathway	Used once a day, usually at night	Pink eye (which usually improves after a few days or weeks), darkening of iris colour (most common with green or hazel eyes), thicker and darker eyelashes
Carbonic anhydrase inhibitors	Brinzolamide, dorzolamide	Reduce the production of fluid in the eye	Applied two or three times a day	Bitter taste
Cholinergic agonists	Pilocarpine	Improve the flow of fluid out of the eye through the conventional outflow pathway	Used three or four times a day	Contracted pupils, headache, eye ache, blurred vision, darkening of the vision

pain to alert sufferers to the problem, despite the optic nerve being damaged.

• **Primary angle closure glaucoma (PACG)**

Also known as acute glaucoma, this develops when access of the aqueous humour to the trabecular meshwork becomes blocked because the iris has moved forward. In this instance the draining angle 'closes', fluid cannot escape from the eye and IOP increases. The pressure rise tends to happen quickly, bringing with it severe pain, red eye, cloudy vision, halos around light sources and, occasionally, sickness.

• **Secondary glaucoma** This describes rises in IOP which result from other ocular conditions or treatments. This type of glaucoma can be either open angle or closed.

• **Developmental glaucoma** This is a rare congenital condition involving eye malformation, which affects one in 10,000 babies.

Causes

In healthy eyes, aqueous humour (the watery fluid that gives the eyeball its shape) constantly flows in and out of the eye, nourishing it. This fluid drains back into the bloodstream at the same rate as it is produced, maintaining the correct pressure in the eye.

In glaucoma, as the eye pressure builds it squeezes the optic nerve, damaging the vital fibres that deliver sight. The first areas to be affected are the off-centre parts of the vision but, if left untreated, glaucoma can progress to tunnel vision and eventual loss of central vision.

The exact mechanisms underlying the

structural and functional changes that occur in glaucoma are not fully understood. Optic nerve damage can occur even when eye pressure is within the statistically 'normal' range – a condition known as normal (or low) tension glaucoma. Conversely, in the common disorder of ocular hypertension, eye pressure can be above the normal level but with no detectable damage to the visual field. Factors such as poor blood supply to the optic nerve and weakness in the nerve itself therefore seem to play a key accessory role in glaucoma development.

Risk factors

Several risk factors have been pinpointed that increase the likelihood of glaucoma development. These tend to be cumulative in their effect:

• **Age** POAG becomes more common with increasing age. Rare below the age of 40, POAG affects 2 per cent of those aged over 40 and rises to an incidence of 5 per cent in the over 65s.

• **Race** People of African Caribbean origin are over four times more likely to develop POAG. The condition also tends to onset at an earlier age and be more severe. Similarly, the incidence of PACG is more common in South East Asians, Chinese and Inuit, making regular testing essential for these groups.

• **Family history** Having a close blood relative with glaucoma increases the risk of developing the condition four-fold or more.

• **Short/long sightedness** People with severe myopia are more prone to developing POAG, while hypermetropia is associated with an increased risk of PACG.

• **Diabetes** Diabetics may be at increased risk of developing glaucoma, although it is not known whether there is a direct link between the two conditions.

• **Sex** Females seem to be at greater risk of developing both normal tension and chronic angle closure glaucoma.

Diagnosis

Most cases of glaucoma are detected during routine eye examinations, underscoring the importance of regular check-ups, especially for the over 40s. If detected early, long-term damage to the optic nerve can be prevented.

Three diagnostic tests are used:

• **Ophthalmoscopy** – examination of the optic disc with a special torch.

• **Tonometry** – a check on the level of pressure in the eye. The most commonly used instrument is the puff tonometer as topical anaesthesia is not required.

• **Perimetry** – this test uses a sequence of spots of lights to check the visual field and pinpoint any areas of sight loss in the off-centre range of vision.

Treatment

The mainstay of treatment for open angle glaucoma is eye drops, which lower pressure within the eye and prevent further damage to the optic nerve. There are many different types, each working via a different mechanism (see table 1). A topical beta-blocker or prostaglandin analogue is generally the drug of first choice, but it is often necessary to add in

other types or use agents in combination.

PACG is initially treated with eye drops and an injection to lower IOP. For urgent reduction of pressure and before surgery, mannitol 20 per cent (up to 500ml) can be given by slow intravenous infusion until IOP has been satisfactorily reduced.

Acetazolamide by IV injection can also be employed in the emergency management of raised IOP – this drug is also used orally as an adjunct to other pressure-lowering treatments. PACG will usually require additional laser treatment or surgery to bypass the blockage in the drainage networks and prevent a recurrence.

Laser treatment is a quick and painless procedure. It enlarges the tiny holes in the trabecular meshwork, making it easier for the aqueous humour to flow out of the eye and thus preventing pressure build up. Surgery for glaucoma – known as trabeculectomy – is rarely employed nowadays thanks to the effectiveness of drug therapy and laser treatment. However, if IOP pressure remains consistently high despite these interventions, a tiny opening in the wall of the eye can be surgically created, allowing excess fluid to drain into the bloodstream. Some patients will need to continue to use

eye drops despite having undergone laser treatment or surgery.

Pharmacy-led counselling on compliance

Pharmacists have a key role in optimising the effectiveness of glaucoma treatment. Efforts to encourage compliance are particularly important given that as many as half of all glaucoma patients fail to use their eye drops correctly. Counselling customers in the regular and correct use of their eye drop, is the key to preventing damage and further deterioration of vision which, left unchecked, can lead to sight loss.

As with any chronic condition, most glaucoma sufferers pay regular visits to the pharmacy to collect their medication, providing ample opportunity for pharmacists to help maximise glaucoma management:

- Suggest compliance aids – for example, keeping eye drops somewhere visible such as next to the bed or near the toothbrush.
- Check that patients know the correct method for instilling eye drops. Common problems include difficulty in aiming or squeezing the bottle, coupled with fear of the bottle nozzle coming into contact with

Advice on eye drop use

- Suggest a simple application approach: sit in front of a mirror, pull down the lower eyelid and let the drop fall into the space between the eye and the lid. Close your eye and gently press on the inside corner with a finger for two to three minutes to close the tear duct and stop the drops from draining away.
- If using more than one type of eye drop, leave at least 10 minutes between applications to prevent the second drop washing out the first.
- Some patients may keep eyedrops in the refrigerator to help tell whether or not a drop has gone into the eye. The sensation of cold liquid on the eye is more pronounced than that with drops kept at room temperature. However, it is best to check with the manufacturer that the product remains viable and stable if stored in such a way.

the eye. You can supply useful tips on eye drop application (see panel above).

Alternatively, offer customers a patient information leaflet or suggest they visit their GP or nurse for (re)education on how to apply the drops.

- Clearly label glaucoma medication with the intended dosing in as large a print size as possible.
- For patients taking more than one type of eye drop, point out recognisable features for each medication such as the colour of the cap or shape and size of the bottle. This can help avoid confusion about which drug to use when.
- For patients with severe self-administration difficulties, consider aids such as specialised eyedrop dispensers.

For references and glaucoma MUR tips go to www.chemistanddruggist.co.uk/update

Helen Boreham is a medical writer with an MSc in medicinal chemistry.

Continuing Professional Development

CPD

ART

- Read the BNF section on glaucoma treatment.
- How user-friendly is your pharmacy for people with impaired vision? Is your lighting bright enough, are there obstacles preventing easy access to the prescription counter, do you offer medicine labels and leaflets in large type? Do you supply leaflets on how to instil eye drops or offer devices that make application easier?
- Work through the FAQs on www.glaucoma-association.com to see what you would say if patients asked you the questions listed. Would your answers correspond with those given?
- Check compliance with your glaucoma patients. Do they return for repeat eye drops at intervals that suggest they are forgetting doses? Investigate as many patients as you have time for, finding out what problems they have. Based on suggestions in the article, list ways you might encourage them to use their drops as prescribed.
- Look at the services offered by the Royal National Institute of the Blind (www.rnib.org.uk) and make note of any that might be useful for customers with sight problems. Services include a catalogue of products for everyday living, an online shop, a helpline and day courses for professionals.

EVALUATE

- Are you now able to offer a better service to patients with glaucoma? Is there anything else you need to know about the medicines used?

Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the March 1 issue, which will cover this month's

three CPP-accredited modules. A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on 01732 377269.

Chemist+Druggist in association with
Genus Pharmaceuticals

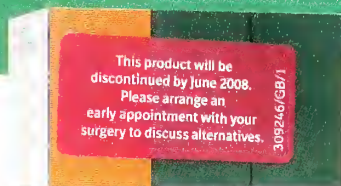


C+D AWARDS
Closing date March 14

Combivent® Metered Aerosol

(ipratropium bromide and salbutamol sulphate)

(MA) Inhaler is to be DISCONTINUED



Combivent® Metered Aerosol

ipratropium bromide and salbutamol sulphate

Pressurised inhalation, suspension

For oral inhalation only

10 ml vial containing
200 metered doses

Patients are being notified via a sticker on each pack and are advised to visit their surgery for a review

Stickers will appear on UK packs only from January 2008



- Combivent MA inhaler will be discontinued by Boehringer Ingelheim by June 2008.
- Boehringer Ingelheim emphasises that the decision to discontinue Combivent MA inhaler is driven solely by the restriction in use of CFCs, and is in no way based on the safety profile, effectiveness or quality of the product itself.
- This discontinuation affects the Combivent MA inhaler only. Combivent Unit Dose Vials (UDVs®) are not affected and will remain available.
- Posters and patient leaflets are available giving details of the discontinuation. Request these from your Boehringer Ingelheim representative.

If you would like further information on Combivent Metered Aerosol, please contact Medical Information on 0845 602 3809

PRESCRIBING INFORMATION (UK)

Combivent Metered Aerosol (ipratropium bromide and salbutamol sulphate)

Presentation: Metered Aerosol containing a combination of ipratropium bromide (anticholinergic bronchodilator) 20 micrograms and salbutamol sulphate (beta₂-adrenergic agonist) 120 micrograms.

Indication: COPD-associated bronchospasm in patients who require regular treatment with both ipratropium and salbutamol. **Dosage:** Adults (over 12 years): two puffs four times a day. **Contra-indications:** Hypertrophic obstructive cardiomyopathy; tachyarrhythmia; known hypersensitivity to any of the components or to atropine or its derivatives. Hypersensitivity to soya lecithin or related food products such as soya bean and peanut. **Precautions:** Immediate hypersensitivity reactions may occur after administration as demonstrated by rare cases of urticaria, angioedema, rash, bronchospasm and oropharyngeal oedema; concurrent administration with systemically absorbed anticholinergics, xanthines, corticosteroids, other beta-agonists, beta-blockers, monoamine oxidase inhibitors, tricyclic antidepressants, halogenated hydrocarbon anaesthetics; not to be used in pregnancy or lactation unless the benefits outweigh the possible hazards to the child. Instruct in correct use and warn not to allow contact with eyes as there have been rare reports of ocular complications (i.e. mydriasis, blurring

of vision, narrow-angle glaucoma, eye pain). Patients who may be pre-disposed to glaucoma should be specifically warned to protect their eyes. If eye pain/discomfort, blurred vision, visual halos or coloured images, with red eyes from conjunctival congestion or corneal oedema develop (suggesting acute narrow-angle glaucoma), treat with miotic drops and seek specialist advice immediately. Advise patient to seek medical advice in the event of acute, rapidly worsening dyspnoea or if response lessens. Use with caution in patients with: recent myocardial infarction and/or severe organic heart or vascular disorders; insufficiently controlled diabetes mellitus, hyperthyroidism, prostatic hypertrophy, pheochromocytoma, and risk of narrow-angle glaucoma. Potentially serious hypokalaemia may result from beta₂-agonist therapy, particularly in severe airways obstruction, xanthine derivatives, steroids, and diuretics may potentiate this effect. Additionally, hypoxia may aggravate effects of hypokalaemia on cardiac rhythm, especially in patients receiving digoxin. It is recommended that serum potassium levels are monitored in such situations. Patients with cystic fibrosis may be more prone to gastro-intestinal motility disturbances. **Side-effects:** In common with other beta-agonists more frequent undesirable effects are fine tremor of skeletal muscles and nervousness, less frequent are tachycardia, dizziness, palpitations or headache, especially in hypersensitive patients. Potentially serious hypokalaemia may result

from beta₂-agonist therapy. In isolated cases there may be local reactions such as dryness of the mouth, throat irritation, dysphonia or allergic reactions. As with other bronchodilators, in some cases cough, in very rare instances paradoxical bronchoconstrictions have been observed. As with other beta-mimetics, nausea, vomiting, sweating, weakness and myalgia/muscle cramps may occur. Allergic-type reactions such as skin rash, pruritus, angioedema of the tongue, lips and face, urticaria (including giant urticaria), laryngospasm and anaphylactic reactions have been reported. As with all beta₂-agonists hyperactivity in children is possible. Prescribers should consult the summary of product characteristics in relation to other undesirable effects. **Pack Size and Basic NHS price:** 10ml vial complete with mouthpiece containing 200 doses £6.77 PL 00015/0191. **Legal category:** POM. **Product Licence Holder:** Boehringer Ingelheim Limited, Eylesfield Avenue, Bracknell, RG12 8YS. For full prescribing information please see summary of product characteristics. Updated August 2007

Adverse events should be reported to Boehringer Ingelheim Drug Safety on 0800 328 1627 (freephone). Information about adverse event reporting can be found at www.yellowcard.gov.uk

A Practical Approach

Veterinary prescribing

**Julia O'Reilly, pre-registration**

pharmacist trainee at Update Pharmacy, takes a telephone call in the dispensary.

"Hello, it's Cath Barker here, I'm one of the vets at the Healthy Pet practice round the corner. Our drug wholesaler has had a fire and can't supply us for a few days. We're desperately short of drugs for post-operative analgesia, and I was hoping you could supply us."

Julia replies: "Certainly, we will if we can.

What do you need?"

"We generally use butorphanol. Have you got any of that?"

"It doesn't sound familiar, but I'll check." Julia ducks away for a moment, then returns to the phone. "No, and I can't even find it in the BNF."

"BNF?" queries Cath. "Oh yes, that's the formulary for human medicines. It can't be licensed for human use then. OK, do you have any morphine sulphate 10mg/ml injections?"

"Yes, we've got plenty of those."

"Right. I need two ampoules urgently, so I'll send the dog's owner round with a prescription straight away. And I'll come in with a requisition for another 10 after I've finished surgery here."

"I think there might be a problem," Julia says. "Private scripts for CDs now have to be written on standardised forms issued by the local primary care organisation, and there are new requirements for CD requisitions too. Hold on and I'll check."

Questions

1. Will the vet need to write the prescription on a standardised form?
2. What are the new requirements for CD requisitions and is the vet subject to them?
3. What details, in addition to those for a CD Schedule 2 POM for human use, will the vet have to put on the prescription?
4. What details, in addition to those for a CD Schedule 2 POM for human use, will have to go on the label of the dispensed medicine?

Answers

1. None of the requirements for private CD prescriptions – standardised form, private prescriber's identification number, sending the prescription to the NHS Prescription Pricing Division (PPD) – apply to veterinary prescriptions.
2. From January 1, 2008, requisitions for CDs for human use should be made on standardised forms obtainable from local PCOs (a good practice, rather than legal requirement). On receipt, requisitions must be clearly marked with the supplying pharmacy's name and address, and be sent to the PPD with the monthly batches of prescriptions for pricing. None of these legal requirements apply to requisitions from vets.
3. Telephone number of prescriber; name and address of owner or keeper of the animal; species of the animal. As the morphine sulphate injections are licensed for human, not animal, use the prescriber must state that it is being prescribed under the 'cascade' process (for further details of the 'cascade' see the Medicines, Ethics and Practice Guide 31, p88).
4. Name of prescribing vet; name and address of animal owner; identification of the animal; expiry date.



This article can help in the following CPD competencies: **C1b, C4b G1h, G1s, G1t**. See www.tinyurl.com/194zu

Probiotics not always harmless, study reveals

Probiotics may be associated with an increased risk of fatal bowel ischaemia in patients with severe acute pancreatitis, a study published this week in *The Lancet* has revealed.

Many patients with severe acute pancreatitis die due to infectious complications thought to start with overgrowth of small-bowel bacteria, and some researchers have suggested prophylaxis using probiotic strains of bacteria.

The study published by *The Lancet* compared two groups of 152 and 144 patients respectively, the first of which were given a probiotic formulation while the second was asked to take a placebo.

Similar rates of infection were seen in both the probiotic and placebo groups, but

patients taking the probiotic treatment had a much higher death rate than those taking the placebo. Some 24 subjects taking probiotics died compared with nine in the placebo group.

The authors argued that the particular formulation used in the study should not be given to patients predicted to develop severe acute pancreatitis, and that other probiotic products should not be administered to patients of this type until the mechanism of any benefit had been revealed.

Further, they said that probiotics could no longer be considered harmless adjuncts to enteral nutrition, especially in critically ill patients and those at risk of non-occlusive mesenteric ischaemia.

www.thelancet.com

Clinical Alerts**SPC Changes****Cubicin powder for infusion**

(daptomycin) Renal impairment and renal failure added to list of side effects.

Xeloda tablets (capecitabine) Warning added on need to take baseline neutrophil and thrombocyte counts. Adverse effects section updated.

Humira solution for injection

(adalimumab) Indications section updated to include information on use with methotrexate.

Topamax range (topiramate) Lithium, glyburide, valproic acid, diltiazem and venlafaxine added to interactions section.

Provigil tablets (modafinil) Additional warnings about serious rash and psychiatric events.

Betaferon powder for injection (interferon beta-1b) Text revised to detail efficacy over three years, rather than two.

www.emc.medicines.org.uk

Poor info causing readmissions

Communications gaps in medicines management are a frequent cause of re-admission, a review of 108 readmitted elderly patients' notes has revealed.

The results published in *Quality and Safety in Health Care* showed that problems with medications accounted for more than a third of the readmissions. In most cases readmission was considered to have been preventable.

Almost two-thirds of the patients were readmitted before a discharge letter had even been typed or were patients for whom a discharge letter had not been produced.

More complete discharge communication could have prevented many of the adverse events that led to the readmissions, the authors concluded.

<http://tinyurl.com/2dk34h>

Clinical News



Wikimedia Commons

Resistant E coli common 'soon'

Health professionals may quickly find antibiotic-resistant E coli strains have become common in bloodstream infections acquired in the community, according to a review published by *The Lancet Infectious Diseases*.

www.thelancet.com

Yellow Card call

MHRA officials have launched a six-week campaign asking pharmacists to mention the Yellow Card scheme to patients. The organisation has issued simplified reporting forms, and has sent posters and leaflets to pharmacies. MHRA chief executive Kent Woods drew attention to the issue last week in a C+D opinion article

<http://tinyurl.com/39nvyyo>

New Products

Nipent 10mg powder for injection/infusion (pentostatin)

Indicated as single agent therapy for the treatment of hairy cell leukaemia.

Hospira, tel: 01926 820820.

Supply Issues

Acnisal 2 per cent cleanser (salicylic acid)

Back in stock following supply issues. Alliance Pharma, tel: 01249 705112.

To get C+D's clinical news and CPD alerts by free email, sign up at www.chemistanddruggist.co.uk/register

Antibiotics may not prevent effusion

Antibiotics prescribed for children with ear infections are not associated with a significant reduction in fluid build up and do not prevent effusion, according to a meta-analysis.

Effusion can lead to a conductive hearing loss of 15 to 40dB, and may have an adverse effect on language and cognitive development, behaviour and quality of life, according to a literature review.

Data from 1,328 children from six months to 12 years randomised to placebo or no treatment revealed that children prescribed antibiotics were only slightly less likely to develop effusion than the

controls. The analysis published by the Archives of Otolaryngology – Head and Neck Surgery – also found the difference in risk between the two groups was not statistically significant.

Weighed against the known negative effects of antibiotic prescribing, the marginal benefit of antibiotic treatment did not justify its use, the Dutch authors concluded.

However, they added that there may nevertheless be benefits in some subgroups of patients with ear infection. *Arch Otolaryngol Head Neck Surg* 2008; 134: 128–132.

C+DAWARDS 08

Don't miss your chance to win the holiday of a lifetime worth £3,500. See p34 for details. Closing date March 14

- ✓ £1.55 RRP – cheaper for your customers, more profitable for you
- ✓ Effective at relieving muscular aches and pains
- ✓ Licensed for the treatment of unbroken chilblains

38%
+wholesaler discount

It's
Back!

PP code 002-4224

Balmosa is a warming pain relieving cream that soothes and relieves the pain of unbroken chilblains and muscular aches and pains. It can also be used to relieve the symptoms associated with strains, sprains, bruising, back pain and sciatica. **Directions for use:** Adults and children over 12: Apply Balmosa cream onto the affected area and gently massage onto the skin. Use Balmosa cream as frequently as required. If accidentally swallowed seek medical advice. **Caution:** Do not apply to inflamed or unbroken skin or near the eyes, nostrils or other sensitive areas. If you are pregnant, breastfeeding or are sensitive/allergic to aspirin or any of the ingredients listed consult your pharmacist before use. Keep out of the reach and sight of children. For external use only. Do not use after expiry date shown. Do not store above 25°C. Active ingredients: camphor 4% w/w, methyl salicylate 4% w/w, menthol 2% w/w, and capsaicin oleoresin 0.035% w/w. Marketing Authorisation Holder: Forest Labs UK Ltd, Bexley, DA5 1NX, UK. Legal Category: GSL. Prescribing information last revised: April 2003.

Sweet relief



The past few years have seen a rise in the availability of honey-impregnated dressings for woundcare, but what makes honey an attractive option and how effective is it? **Emma Wilkinson** reports

Honey is one of several ancient remedies that is going through a modern resurgence in use – along with maggots and leeches used to debride and promote blood flow in difficult to treat wounds.

The use of honey as a healing agent goes back thousands of years and it was first documented as a wound treatment by the Egyptians in 2,000 BC.

However it is only in recent decades that laboratory studies have found it to have antibacterial properties and have positive effects on some of the processes promoting wound healing.

Commercial honeys intended for use on wounds are now available. They have standardised antibacterial activity and are sterilised by gamma irradiation.

Regulated CE-marked honey products attained Drug Tariff status in the UK in 2004, opening the way for its use in modern woundcare.

And a search through the medical literature also shows an increase in studies assessing its use, albeit with conflicting results.

Antibacterial properties

Honey inhibits a broad spectrum of bacteria and fungi and many positive effects on woundcare have been reported.¹

Although its effects are not yet fully understood, its high sugar content, low water content and acidity all contribute to its effect on limiting growth of micro-organisms and explain why it rarely "goes off" even when left in the cupboard for long periods.

In scientific terms, honey is a super-saturated sugar concentrate with only 15 to 21 per cent free water – meaning there are too few water molecules to support the growth of micro-organisms.

Its pH of between 3.2 and 4.5 can also inhibit many pathogens. But the major antibacterial activity is through hydrogen peroxide, created by an enzyme secreted from the bee into the nectar, which assists in the formation of the honey and helps to preserve it.

The enzyme is pretty inactive in full strength



honey but according to the University of Waikato Honey Research Unit in New Zealand, on dilution of honey the activity increases by a factor of 2,500 to 50,000, producing a "slow-release" antiseptic at a level, which is antibacterial but not tissue-damaging.²

Researchers have found other antibacterial substances in honey, which explains how some still have antibacterial properties when hydrogen peroxide is absent, but not in high enough quantities to have any substantial effect.

Which honey?

It is known that in ancient times, physicians chose specific types of honey for distinct medicinal purposes, suggesting they were aware of the variation in composition of different honeys.³

A study of 345 samples of New Zealand honeys found major differences in overall antibacterial activity, which researchers said was mainly due to variation in the level of hydrogen peroxide.⁴

Among those studied, honeydew honey from the conifer forests of the mountainous regions of central Europe and honey from manuka in New Zealand has been found to have a particularly high antibacterial activity.

Honey used for wound healing needs to have been tested in the laboratory, sterilised, stored at low temperature and not exposed to light to preserve enzymatic activity.

Leg ulcers

In leg ulcers, some researchers have reported that use of honey eradicates unpleasant smells associated with the wound, most likely due to the inhibition of anaerobes.⁵ And case studies have been reported of successful healing with use of honey dressings.

Specialised dressings for this purpose are available in the UK. But a recent trial by New Zealand researchers of honey dressings in the treatment of venous leg ulcers found no significant differences between that and normal care after 12 weeks.

They also found that treatment with honey



was more expensive and probably associated with more adverse events.⁶

MRSA

There has been a lot of interest in honey as a potential treatment for wounds infected with antibiotic resistant bacteria. Laboratory research presented at the first Wound Healing Congress on two different types of honey showed the antibacterial potency was well in excess of that needed to stop the growth of MRSA and vancomycin-resistant enterococci (VRE).

The researchers pointed out that since honey had already been proven to work in clearing wounds of infection with other bacteria where conventional treatments had failed, there is justification for trying it for the treatment of wounds infected with MRSA and VRE.⁷

More recently, a German team of researchers reported full healing in seven children whose wounds were either infected or colonised with MRSA. Previous treatment with antiseptics and antibiotics had failed to eradicate the clinical signs of infection.⁸

Also very recently, doctors in the Maxillofacial Unit at the Royal Surrey County Hospital reported treating patients with manuka honey dressings for the past year in their woundcare clinics and on the wards. The honey was successful in treating wounds which had proved resistant to antibiotics. In these patients the honey-impregnated dressing was applied directly to the wound and covered in a second absorbent layer to contain the honey.

In one 80-year-old man, a wound from a split skin graft in his upper arm was contaminated with MRSA. After use of the honey dressings, the wound healed in two weeks.

The team have been so impressed, the honey dressings are now their first-line treatment and no adverse effects have been noted.

They believe the effects may be in part due to the stimulation of immune responses, in particular the stimulation of inflammatory cytokines from monocytes.⁹

However, not everyone is convinced and there have been calls for randomised controlled trials to work out the practical details of using honey

in chronic wounds and to compare its use with standard treatment.

Widespread use

So what is the place for honey in woundcare? Many reports are anecdotal and there is no doubt it is becoming more commonplace but one thing most experts agree on is that more randomised controlled trials are needed.

There is lots of evidence from *in vitro* studies that honey inhibits growth of bacteria but the exact mechanisms by which this happens are not clear. What that research does show us is the biological plausibility for honey's benefits in woundcare. The treatment of MRSA with honey is an exciting prospect but without further research it is unlikely to be adopted for widespread use. ▶



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Product news

PlastOff makes ready for consumer launch

PlastOff is a new product designed to make removing plasters easier and less painful.

The launch is being supported by an ongoing publicity campaign including direct marketing and a promotional website with a demonstration film (www.plastoff.com).

The consumer launch will coincide with availability in the shops in early summer and it will include advertising, PR and other promotional activity primarily aimed at family, women's interest and healthcare media.

PlastOff's manufacturer FMP would like to hear from pharmacists who know of people with conditions who could benefit from using PlastOff and would like to be a case study. FMP is particularly interested in people of all ages with sensitive skin or other skin conditions.

Price: £4.99/30ml

For more information: Juliet Shaw at Resource Marketing on 01229 400210 or juliet@resourcemarketing.co.uk



T&R offers Acriflex for burns



Acriflex Cooling Burns Gel is a new product from Thornton & Ross.

Using OSMO4 technology to hydrate the skin and minimise possible scarring, the product provides cooling relief to minor burns and scalds, says the company.

It is preservative, alcohol and perfume free and is suitable for adults and children over two years old.

Price: £3.99 for 30g

Thornton & Ross, tel: 01484 842217

C+D AWARDS

Only three weeks left to submit your entry

**closing date
March 14**

NEW

a major breakthrough for minor burns



New Acriflex Cooling Burns Gel

uses OSMO4 osmotic technology which has been clinically proven to soothe by rapidly cooling the skin tissues to relieve discomfort, reduce the redness of inflamed skin, hydrate the surface layers of the skin to promote its natural repair system and kill bacteria through physical action without drying the skin.

Find out more from your T&R representative, or call 01484 842217.



CE
CE0459

✓ cools ✓ reduces inflammation ✓ hydrates ✓ promotes repair

Presentation: Glycerin, PEG-8, caprylyl glycol, sodium polyacrylate, carbomer, sodium hydroxide and purified water. Indications: for application to superficial burns such as may occur in the home, sun-burn and minor skin irritations. Dosage and Administration: For adults and children over 2 years of age apply to unbroken skin and massage gently. Leave for a few minutes to penetrate. Repeat 2-3 times daily. Contradictions: Sensitivity to the product or any of its ingredients. Warnings: Avoid contact with the eyes. Do not use after the expiry date. Store at room temperature. Keep away from sources of heat. Keep out of the reach of children. Legal Status: Class IIA medical device. Pack Size: 30g RSP excl VAT: £3.29. Date of preparation: January 2008. Further information is available from Thornton & Ross Ltd, Linthwaite, Huddersfield HD7 5QH.

PCiPM

Practice Certificate in Pharmacy Management

Coming soon with your C+D...

The Practice Certificate in Pharmacy Management is a distance learning course delivered in association with Medway School of Pharmacy. It is designed for anyone who manages, or aspires to manage, a community pharmacy.

Ten training modules will be delivered FREE to C+D subscribers every month from March 2008, supported by an educational grant from McNeil Products Ltd.

Together these 10 modules make up two Short Courses within the Medway Short Course Pathway. Each course, on completion, is worth five points towards a postgraduate Certificate qualification.

- Building your team
- SOPs and audit
- Leadership and communication
- Managing risks and solving problems
- Managing yourself
- Strategic planning
- Corporate governance
- Project management and change
- Communication in organisations
- Marketing your business



For information on the course and registering for assessment, please complete the slip below and return to Pauline Sanderson, CMP Medica, Riverbank House, Angel Lane, Tonbridge, Kent, TN9 1SE. Tel: 01732 377269. Email psanderson@cmpmedica.com

YES, please send me more information on registering for the
Practice Certificate in Pharmacy Management



Name: _____

Address: _____

Postcode: _____

Email: _____

in association with
Medway School of Pharmacy

Supported by an educational grant from



University of
Kent



Multibionta springs into action

Probiotic multivitamin Multibionta is on TV in a £1 million spring campaign.

Targeting men and women with active lifestyles, the ad describes the product as a unique three layer multivitamin. It will be screened on Channel 4, ITV1, ITV2 and five.

Multibionta contains 100 per cent of the RDA of all vitamins and minerals needed while the blend of probiotics helps maintain a healthy digestive system, says the manufacturer Seven Seas.



Exclusive Boots deal for MigraHerb

MigraHerb, an alternative remedy for migraine prevention, has been launched exclusively in Boots.

Distribution will be extended to independent pharmacies in future.

MigraHerb is registered with the MHRA and licensed for the

prevention of migraine headaches.

Containing feverfew, one 100mg capsule should be taken daily.

Price: £7.99/30
MH Pharma
Tel: 01628 400 608

Bodyform joins up with fashion label

Fempro brand Bodyform has joined up with the Preen fashion label for its latest promotion.

Preen collections on show in New York and Copenhagen were supported financially by the brand. The partnership will continue throughout the year with a

collaborative project planned. The link-up will be highlighted on packaging and in advertising.

Product info:
SCA Hygiene
Tel: 01582 677400

Ready, steady, glow

Skincare brand Simple is driving sales of its Daily Radiance products with a £500,000 marketing campaign.

Taking a 'Brighten your day' theme, promotional activity spans the Metro newspaper, PR, sampling and online activity. As well as offering prizes and coupons on its own website, the brand has teamed up with the Pigsback offers and rewards site.

Commuters aged 20 to 34 years are being targeted with an experiential campaign during rush

hours at London, Manchester and Leeds railway stations. Further support is running in Birmingham and Cardiff shopping centres.

The Daily Radiance range comprises foaming cream cleanser, moisturiser with SPF10 and an eye cream. All contain mango extract and light-reflecting particles.

Product info:
Accantia Tel: 01217 126523
www.simple.co.uk
www.pigsback.com

Products in brief

Call Jenks for Nad's

Australian hair removal brand Nad's has appointed Jenks to manage sales and trade marketing. The company is predicting a year of growth for Nad's in terms of distribution and consumer penetration.

Jenks Sales Brokers
Tel: 01844 293600.

Eye comfort

Can-C eyedrops has been launched by Butterflies Healthcare. Containing antioxidant N-acetylcarnosine, the product is positioned as an eye lubricant. One to two drops can be applied four times daily. The shelf life once opened is 30 days.

Price: £27/2x5ml; Pip code: 335-4859; Butterflies Healthcare
Tel: 0845 838 6704.

Product info:
Seven Seas
Tel: 01482 375234

Summer comforts

Flip flops could be more comfortable this summer thanks to two new products from Scholl.

Party Feet Flip Flop Strips fit over the toe post and are designed to protect the feet from rubbing. For high heeled flip flops, the limited edition Toe Post Cushion has been developed. This protects the tender area between the toes from rubbing and cushions the balls of the feet. Both products are

discreet, reusable and washable. They will launch in the grocery sector in spring and in pharmacy in summer.

Price: strips £1.99; toe post cushion £4.99

Product info:
SSL International
Tel: 0870 122 2689
www.scholl-footcare.co.uk



Products advertised on TV next week

Beechams: All areas

Breathe Right: All areas

Buscopan: GMTV

Buttercup Cough Syrup: All areas except five

Covonia: GMTV, Sat, five,

Cura-Heat: All areas, except GMTV

DulcoEase: GMTV, Sat, five, LWT, CAR

Imigran: All areas

Lyclear SprayAway & Repellent: GMTV, Sat

NiQuitin: All areas

Seven Seas JointCare & CLO: All areas

Vagisil Wash: All areas

PharmaSite for next week: Ibuleve – windows, Ibuleve – in-store, Ibuleve – dispensary

Pharmacy channel: NiQuitin, Fusion Condoms, Clearly Herbal

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, ITV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Scratch Resistance.

The 'itch' of eczema is recognised by doctors and sufferers alike to be the worst symptom of the condition, causing sleep disturbance in 85% of cases¹

We've drawn upon 50 years of skincare experience to formulate E45 Itch Relief Cream specifically to help ease this distress.

Moisturising urea and local anaesthetic lauromacrogols combine in a dual-action formula to soothe the itch whilst hydrating and smoothing the affected skin.² These therapeutic benefits are delivered in a well-tolerated and highly acceptable emollient cream.³

Either a "good" or "very good" improvement in skin condition was measured in 74% of patients.³

E45 Itch Relief Cream.

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EXPERT E45



DERMATOLOGICAL

E45

Itch
Relief
Cream

Lauromacrogols
and Urea

Prescribing Information E45 Itch Relief Cream. E45 Itch Relief Cream contains lauromacrogols 8.0% w/w and urea 5.0% w/w. **Uses:** For the treatment of pruritus, eczema, dermatitis and scaling skin conditions where an antipruritic and/or hydrating effect is required. It may also be used for the continued treatment and follow-up treatment of these skin diseases. **Dosage and administration:** Adults, the elderly and children: Apply to each affected area twice a day. The duration of

treatment depends on the clinical response. **Contraindications:** Patients with known hyper-sensitivity to any of the ingredients. It should not be used to treat acute erythroderma, acute inflammatory, oozing or infected skin lesions. **Special warnings and precautions for use:** May cause irritation if applied to broken or inflamed skin. **Pregnancy and lactation:** There are no specific restrictions concerning its use during pregnancy, but it is not to be used on the breasts immediately prior

to breastfeeding during lactation. **Undesirable effects:** E45 Itch Relief Cream has been reported to cause a burning sensation, erythema, pruritus or the formation of pustules. Contact allergy has also been reported. **Package quantities:** 50 g and 100 g tubes. **MRRP:** 50 g £3.39, 100 g £5.44. **Legal category:** GSL. **Product licence number:** PL 00327/0122. **Product licence holder:** Crookes Healthcare Ltd, Nottingham, NG2 3AA. **Date of preparation:** December 2003.

Information about adverse event reporting can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Medical Information Unit, Reckitt Benckiser, Hull (0500 455 456).

References: 1. NPS Survey, March 1999. 2. Uschmann M et al. The German Dermatologist 1992;8;1138-1143. 3. Vieluf D et al. Z Hautkr 67;8:816-821. **Date of preparation:** October 2007.

IRL Form07

Products in brief

Countertop colours

The range of Poslign ePoS terminals available from Aures Technologies has been extended. Options suitable for the pharmacy sector include a modular solution comprising the retail PC Poséo and the additional screen, OLC1S, available with a clip-on system allowing the colour to be changed, says the company. The PC can be hidden below while the elegant touchscreen stands on the counter, adds Aures. Aures Technologies Tel: 01928 591222.

Testing giveaway

Free home cholesterol test kits are being offered to customers buying Solgar's Sytrinol 60 capsules throughout March.

Sytrinol was launched over a year ago. It contains citrus and palm fruit extracts and can be used to lower high cholesterol. Solgar products are available to pharmacies within the M25 area. Solgar, tel: 01442 890355.

Quick shave in the shower

Nair Shower Power hair removal cream has been launched. It is said to give results in three minutes, depending on hair thickness. The aloe vera-containing cream moisturises the skin and comes complete with a sponge for application. Visitors to the Nair website can get tailored advice or

email questions to the brand's technicians.

Prices: £5.69/125ml
Pip codes: 33S-6433
Church & Dwight
Tel: 01303 858700
www.naircare.co.uk

Doctoring pain

Tower Health has extended its offering with the launch of two products.

The PainDoctor is a battery powered TENS device that includes a massage function. It has two interchangeable heads and is supplied with a conductive gel to intensify the TENS therapy, says the company.

Classified as a Class IIa CE medical device, the PainDoctor uses include arthritis, rheumatism, osteoporosis, sciatica, migraine

and sports injuries.

The second new product, the Salitair, is a salt therapy device said to ease breathing. It can help sufferers of asthma, sinusitis, bronchitis and snorers among others, says Tower.

Prices: PainDoctor £54.95;
Salitair £19.95
Tower Health
Tel: 0115 982 3745

Neilmed knows noses

Two items have been added to Neilmed's range of nasal healthcare products.

NasoGel is a saline nasal gel containing sodium hyaluronate and aloe vera for prolonged moisturisation of dry nasal passages, says the company.

Causes of dry, irritated nasal passages include air travel, oxygen, atrophic rhinitis and Sjogren's syndrome.

NasaMist is a sterile, preservative-free saline spray that protects, cleanses and moisturises the nasal passages. The solution is gentle and non-stinging, says Neilmed. It delivers a fine mist to moisturise the nasal passages.

Pip codes: NasoGel 334-7580;
NasaMist 334-7622
Neilmed
Tel: 0800 032 6073

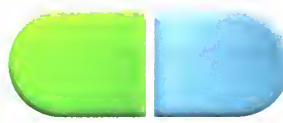
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Clarins covers all climates

HydraQuench is a new range from Clarins said to protect all skin types in all climates and from pollution.

On shelf from next month, the range includes five products, all containing fair trade Katafray bark extract from Madagascar to boost hydration. Intensive Serum should be applied daily under a moisturiser. It is supplied in a frosted blue glass pump bottle.

HydraQuench Rich Cream is designed for very dry skin or cold climates while the range's

regular Cream is for normal to dry skin in moderate climates. Cooling Cream-gel suits normal to combination skins or hot climates and completing the line-up, the Lotion offers SPF15 protection.

All offer a fragrance of "green floral notes of Bulgarian rose, fig and lilac," says Clarins.

Product info:

Price: from £30 to £35
Clarins
Tel: 020 7307 6700

CCS steps up activity

A foot bath salt product has been added to the CCS footcare range from EC DeWitt.

Comprising 100 per cent urea, the salt is designed for use on hard skin and cracked heels. It is presented in a box containing five sachets. A promotional 175ml pack

off CCS footcare cream is currently available containing a free pair of socks for use with the product.

Price: £3.99/five x 15g
Pip code: 334-5212
EC DeWitt Tel: 01928 756800

Haircare heats up

The Tresemmé haircare range is to be extended next month with a raft of new products. Colour Thrive shampoos, conditioners and salon intensive conditioning treatments are designed to maximise colour vibrancy and minimise fading on coloured hair. Blonde and brunette variants will be launched.

For heat styled hair, the Thermal Recovery range contains extracts of aloe vera and almond oil to restore softness and shine. It comprises shampoo, conditioner and an

intensive repair and rehydration treatment.

Completing the launches, Thermal Creations is a styling range designed to work with heat. It comprises a volumising mousse, iron style and hold spray, straightening balm and curl activator spray.

Price: from £3.79 to £4.99

Product info:

Alberto-Culver, tel: 01256 705000

C+D AWARDS 08

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HOW TO MAKE THE MOST OF...

Point of sale

Ever wondered if all that cardboard for point of sale (PoS) material could actually help you sell more? *Small Business* investigates

If you believed the promotional fliers offering you merchandising and point of sale kits, you'd expect them to reach onto the street and drag in customers waving wads of money, begging you to sell them product X in large quantities. I know because I have written such fliers. Reality is, of course, different.

It's easy to take a cynical view of display material, but you dismiss it at your commercial peril. Careful, planned, orderly and, indeed, creative use of PoS is a money spinner. It does stop customers in their tracks; it can persuade them to repurchase; it will increase the average basket size. In addition, it's well produced, it supports manufacturers' other marketing activities and it's free. So, what can it deliver and how do you get the best out of it?

The significance of PoS and merchandising materials in producing sales is hard to quantify, but you can be confident that the manufacturers who provide it are convinced of its importance. The industry body, POPAI (Point of Purchase Advertising Institute and, yes, it is pronounced popeye) estimates that £850 million is spent on PoS and merchandising materials per annum in the UK. Hard nosed businesses don't scatter that sort of money around for fun.

Plan ahead

Start with a PoS planner – a simple diary or year-planner which you can update as the year progresses. Territory reps should be as keen as mustard to have all their brands' PoS plans in this, enabling you to see quickly where you will have a potential log-jam or gaps.

A plan which gives you a constant, relevant, regularly changing programme will deliver results best of all and it will also help with ordering. Within this the reps should be able to tell you when PoS kits will be delivered, whether



they will build the display and when any associated advertising will

run. It will also help you get the

best deal both in buying and support material if there's competition for your display space. Finally, include any local NHS trust initiatives and local anomalies for which you might need support – and ask for that support!

Ask your suppliers

Suppliers to pharmacies do a good job all round. There are plenty of regular programmes responding to the various seasonal prompts with other programmes in place to take advantage of such issues as the smoking ban in public places.

You should note that, compared to other retail sectors, the pharmacy trade gets a lot more support from suppliers and more hands-on input from territory reps. The content of support varies quite considerably. Numark produces

posters with five key products, A5 for in-store, A1/2 for windows plus shelf barkers. Lynne Henshaw, Numark director of trade marketing, says the key issue is to dispel the myth that independent pharmacies are expensive.

Rowlands Pharmacy Group provides stores with posters, barker cards and clip-on bus-stop cards. GlaxoSmithKline has a wide variety of items during its quarterly programmes. As well as window posters, any attention grabbing devices, items with moving elements and clocks are both popular and effective.

McNeil, formerly Pfizer Consumer Healthcare, says that counter display units are very good for P medicines and build on the heritage of the pharmacy. In addition, oversized dummy packs are key in drawing the consumer's eye to new product development (NPD). Wyeth, with its lead brand Anadin, varies its PoS offer, but these materials could include shelf barkers, window stickers, counter units and display dummy boxes.

resources



Numark pharmacist Keith Long makes use of multiple signposts to guide shoppers

Do pharmacies use PoS well? The marketing experts at the suppliers vary in their responses from "definitely, yes" to "in honesty, no". That could reflect different expectations but it demonstrates that somewhere in the middle (where I suggest the majority lie), there is valuable room for improvement. Reading is very valuable: the front of the store is what the customer experiences long before your dispensing excellence. Well used PoS is an important ingredient in making it fresh, interesting and sharp looking. By contrast, if the front of store is a mess you can lose up to 80 per cent of your POM turnover.

Training and expertise is a complex issue. Merchandising and PoS skills are learned and the territory reps are keen to provide the training, since they themselves are experts in this field. Thereby hangs the problem. Even a retail-enlightened pharmacist is unlikely to take to

being taught PoS tricks by a young(ish) rep. Have them teach staff members instead. It should be a popular job – for someone with the right creative mindset.

It works best when staff feel confident that they're doing it right. Rowlands includes PoS skills as part of its induction training. It also sends out a booklet telling staff what to do when and a photograph showing what goes where and how it should look. This might seem like talking down to staff, a little Blue Peterish – here's one I made earlier – but in practice even very experienced staff appreciate the guidance. Numark uses a similar approach, sending out a magazine called Counter Assistance which goes through a similar process of explanation and demonstration.

McNeil has developed a training pack for pharmacists and MCAs to use that is called Essential Selling Skills. There are specific

Photo: RBH Salmons (PR) Ltd



modules that advise on general merchandising as well as promotional activities.

In addition, C+D has a Retail Skills course (call Pauline Sanderson on 01732 377269) that covers customer service skills and how to create good displays, among other topics.

While the independent pharmacist can rely on the reps to place PoS and build displays for them, in many cases this is probably best avoided. This is an important part of your business and it should be under your control.

Best use of PoS

It is my view that the best use of PoS is achieved by personalising it to the store in question. The reason is simple: if it's saying what you want, rather than what the brand manager thinks is right for the country as a whole you're going to use it more, give it greater prominence.

Digital print makes this possible on all sizes from A5 to monster (certainly bigger than your windows). It's gaining ground in the pharmacy trade, too. Rowlands has 12 templates which can be personalised to the individual store.

Anadin says that it listens to pharmacy customers' wants and incorporates them into the plans. Numark says it will respond to the requests of retail-conscious pharmacies, but Ms Henshaw says "they don't ask enough". This is a regular comment – the more you ask, the more and better you'll get; PoS is one of those marketing disciplines that really can be influenced by the retailer.

So, if you see a clever piece of PoS being used elsewhere, in any retail trade, especially if it is obviously working, talk about it to reps or marketing departments. Be brave – be ready to be a guinea pig for a new idea.

The key point is that PoS has huge potential for innovation and adventure. There is every reason why such ideas can be proved in the independent trade, not least because independents have more flexibility, more freedom to try new ideas. Retailers have to show enthusiasm for quality original PoS and merchandising and use it properly, while manufacturers need to sell their package with compelling commercial reasons. The profits will only accrue if everyone's got the focus right.

Paul Clapham is a freelance writer who specialises in business matters

08

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"I've been a Pharmacist Store Manager for about three and a half years now. Before that I had worked as a pharmacist, as well as in resourcing and sales, all within Boots. With the support of my line manager and area office, I've never had to push for promotion. They find out if you're interested in progressing and – with some hard work from you – they take that on and get you where you want to be. When I applied for this job it was a big step, so straight away a development plan was put in place, which really helped me.

As a Pharmacist Store Manager I feel I have more variety, and more challenge. I don't lose any of the professional parts of the role, or the people contact. In fact, because I get to deal with my customers and my team, I get to work with even more people, and that's what I really like."

Amy, Pharmacist Store Manager, Wirral

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From: **Hawkeye on the web**Date: **Sat 23.2.08**Subject: **Testing... testing**

Last year Britons
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£99 million
on self-diagnostics

From the dangers associated with the illicit supply of POMs without prescription to the vast counterfeit black market, drugs have grabbed the headlines when it comes to stories about the impact of the internet on healthcare.

Much less has been said about the availability of diagnostic equipment on the net, but research recently published in the Journal of the Royal Society of Medicine might change this (www.tinyurl.com/2pq9aj).

The study, carried out by staff at Birmingham Women's Hospital, looked at 168 websites hawking home test kits relating to allergies, hepatitis, HIV, thyroid, prostate cancer and chlamydia. It assessed the information on the sites against an 11-point quality checklist of best practice.

The results make predictably uncomfortable reading, with the overall level of patient information described as "poor". Only 14 per cent of sites complied with eight or more quality items and just one demonstrated compliance with all 11 points.

Where a test returned a positive result only 38 per cent of sites recommended a subsequent course of action and where it was negative this fell to 26 per cent.

Market trends don't reflect these concerns,



however. Last year Britons were expected to spend £99 million on self-diagnostics, according to market analyst Mintel, and the figure is forecast to rise 60 per cent to £158m by 2012 (www.tinyurl.com/yskjym).

Most of these kits in question are for blood pressure, blood glucose and fertility, but testing is set to expand into the area of mental illness with a new saliva test that checks for genes that increase the chances of suffering from bipolar depression or schizophrenia (www.tinyurl.com/yu5l2w).

Experts fear there are real dangers that inaccurate and misleading results from ever-more complex tests could bring either false reassurance or unnecessary anxiety and, in turn, the potential for over-use of health services. In more extreme cases, inaccurate self-diagnosis has the potential to lead to misguided, internet-based self-medication.

What do you think?

Email thawkins@cmpmedica.com

... your views on the C+D website ...

Fees unlikely to fall in 2009

Posted by David McNaughton, on 15/02/2008 13:44

The arrogance of the Society (both officials and elected members) to force whilst they can a huge fee increase to cover the officials' pensions and build up a reserve before the expected mass evacuation in 2010 is astounding.

Pharmacy devastated by arson attack

Posted by Mukesh Lad, on 17/02/2008 12:52

Pharmacists try so hard to provide for our communities, but parts of our community try so hard to destroy the good work we do. Shame on the mindless criminals.

From the Forum – 2008 prediction

Posted by Anonymous on 15/2/08 16:23

Something has happened! I read this week that six or seven actual living pharmacists have contacted their MPs and received a welcome.

From the Forum – CD record keeping changes

Posted by Syd Bashford on 15/2/08 15:00

I agree, changes are a total waste of time and money!! Grr... And now I see that the recommendations from the RPSGB are that we should also have a weekly "checked by" and "verified by" entry on all the sheets... No way unless that is enforced. Not wasting 1 hour a week doing that on a weekly basis.

To post a comment, register for free at www.chemistanddruggist.co.uk/register



C+D Update 2008

Thinking about your CPD?

With mandatory continuing professional development for practising pharmacists coming closer, it is time to start thinking about the continuing education you want to undertake in 2008.

Pharmacy Update is back in 2008 with new sections such as 'MUR Tips' and 30 plus modules covering key areas of practice.

What if I miss a module or question paper?

Go to the new C+D website at www.chemistanddruggist.co.uk/update to download any modules or question papers you have missed during the year.

Why should I sign up?

- You'll be able to access over 30 accredited modules, which can be included in your RPSGB 'Plan & Record' CPD portfolio for 2008.
- The course provides you with straightforward self-test

questions and evidence of completion for your CPD portfolio.

- Northern Ireland pharmacists who enrol for Pharmacy Update in 2008 will have their registration fee paid by NICPPET.

Enrol a colleague and save £10

You can save £10 on the £32.50 registration fee simply by encouraging a colleague who did not register for Update in 2007 to register for Update in 2008.

For every colleague that is enrolled, Update sponsor Genus Pharmaceuticals will donate £10 to charity TB Alert (www.tbalert.org).

- Visit www.chemistanddruggist.co.uk/update to download a Colleague registration form.

Sounds great! What do I need to do?

- Register by post by sending the completed form to: Pharmacy Projects, Riverbank House, Angel Lane, Tonbridge, Kent, TN9 1SE.
- Phone Pauline Sanderson on 01732 377269 for credit or debit card payments only.

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Pharmacy Update 2008 registration form

Please register me for Pharmacy Update in 2008.

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- ☐ Please charge £32.50 to my credit/debit card
- ☐ I am enrolling a colleague (form enclosed). I enclose a cheque for £22.50/charge my credit/debit card £22.50

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- ☐ I am a pharmacist registered and practising in Northern Ireland and wish to register under the NICPPET scheme (DO NOT SEND/AUTHORISE ANY PAYMENT).

My PSNI registration number is: _____

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